Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6016794 08/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3089 OLD JACKSONVILLE ROAD **BRIDGE CARE SUITES** SPRINGFIELD, IL 62704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S 000 Initial Comments S 000 Complaint 1946216/IL115116 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)1)3) 300.1630d) 300.3220f) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care Attachment A The facility shall provide the necessary Statement of Licensure Violations care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

09/16/19

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C IL6016794 B. WING 08/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3089 OLD JACKSONVILLE ROAD **BRIDGE CARE SUITES** SPRINGFIELD, IL 62704 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 1 S9999 plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation and a notation made in the resident's record. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been

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issued to assure facility compliance with such

orders. (Section 2-104(b) of the Act)

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AND DIANIOS CODECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6016794	B, WING		08/2) 9/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS CITY ST	TATE, ZIP CODE	1 00/2	.5/2015
BRIDGE	CARE SUITES	3089 OLD	JACKSONVI ELD, IL 6270	LLE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
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		ee, administrator, employee or hall not abuse or neglect a				
	These Regulations by:	were not met as evidenced				
	review the facility 1) immediately, admin narcotic pain medic implement non-pharinterventions for four R4, and R10) review failed to acquire meand acquire a controfrom the physician R2, and R3) reviewed in the sample of 11. experiencing distres 24 hours and R3 experiencing excrucing excrucing experiencing excrucing excrucing excrucing excrucing excrucing excrucing excrucing excrucing excrucing patherapy.	rmacological pain or of five residents (R2, R3, wed for pain. 2) The facility dications from the pharmacy olled substance refill request for three of five residents (R1, ed for medication availability. These failures resulted in R2 ssing, miserable pain for over periencing "pain is a 'nine' excruciating" pain for 15 es resulted in R2 and R3 ciating pain resulting in hese failures also prevented shysical and occupational				
	"Purpose To ensure medications are pro	ing Medications policy states that routine and emergency vided to the guests" and der new medications, staff is				:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		IL6016794	B. WING		1	C 29/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY S	TATE, ZIP CODE	1 00/3	20/2010
	CARE SUITES	3089 OLD	JACKSONVI ELD, IL 6270	ILLE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			
	record. The order is via ePrescriptions for co faxed to the pharma a message will be sin the electronic recre-sent to the pharm medication to be se facility is unable to due to an issue with the physician/on cal an attempt to obtain successful in obtain medication, the gue be allowed to bring is medication and "If the medication fail, if notified and the Med script until a valid so prescribing physician."	ont to the facility. At times the obtain controlled substances a prescription. In this case, if physician will be contacted in the script. If the facility is not ing a valid script for the st or responsible party may in a personal supply of the both of these attempts to fill the Medical Director will be dical Director may fill a short cript can be obtained by the n."				
	documents, "All gue of pain control that coorder to prevent unrum whatever the experie existing whenever he self-report is the preventief is the alleviation to a level of comfort guest and is demonstrated guest's pain scale rescreen for the present to reassess pain into the present to reassess pain into the peak effect, You associates will come	d Pain Management policy sts will receive the best level can safety be provided in elieved pain. Pain is encing person says it is, e/she says it does. If the says it does are red indicator of pain. Pain on of pain or reduction in pain that is acceptable to the strated by a decrease in the strated by a decrease in the strated by a decrease in the strated by a least every insibility of the licensed nurse ensity once a sufficient time pharmacological treatment to our nurses and personal care as by regularly to see how you to the pain medicine as soon				

Illinois Department of Public Health

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6016794 08/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3089 OLD JACKSONVILLE ROAD **BRIDGE CARE SUITES** SPRINGFIELD, IL 62704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 4 S9999 as you start to have pain and report unrelieved pain after being medicated. The longer you wait the worse the pain gets, the harder it is to control. We will evaluate your use of the medications and help you learn how to use them in the most effective manner to treat your pain. As a partner in your health care, your caregivers will depend on you to tell them how you feel. Based on you own comfort level, your health worker will make a pain management plan. Rating your pain: While in the facility you will be ask you to rate your pain. A pain scale has a face that you can point to that will show us how much pain you are feeling. A zero indicates no pain. A six indicates distressing, miserable pain. An eight indicated intense, dreadful, horrible pain. A ten indicated worst possible, unbearable, excruciating pain (crying face). Will ask what type of pain you are having and what works for you. Treating pain consists of medications, cold packs, exercise. ultrasound, and therapy. On 8-26-19 from 9:10 AM to 9:30 AM R2's call light was on. At 9:30 AM V10 (Certified Nursing Assistant/CNA) answered R2's call light. R2 informed V10 that she needed a pain pill for a migraine and nausea. V10 proceeded to turn R2's call light off and reported to V5 (Licensed Practical Nurse/LPN) that R2 was requesting a pain pill and was nauseated. On 8-26-19 at 9:35 AM, R2 was lying in the dark with a wet towel on her head and over her eyes. R2 stated. "I had been waiting for over 40 minutes to have my call light answered. I have an excruciating headache and stomach ache and need a pain pill." On 8-26-19 at 10:50 AM R2's call light was on and V10 answered immediately. R2 complained

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AND PLAN OF CORRECTION INTERCATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		IL6016794	B. WING		_	/2019
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
BRIDGE	CARE SUITES		JACKSONV ELD, IL 627			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
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S9999	Continued From pa	ge 5	S9999			
	off R2's call light an complaining of naus	40 AM to 11:10 AM V5				:
	residents (R3, R4, F	nister medications to other R5, and R6).				
	minutes after reque entered R2's room a medications. During had to request a pa she was having sev head and requested	O AM (one hour and fourty sting pain medication) V5 to give R2 routine morning g this time, R2 was crying and in pill from V5. R2 stated that ere pain to the abdomen and I a Tylenol #3 for the pain. V5 ol-Codeine #3 300-30 mg let to R2.				5
	basin containing voi abdomen. R2 state not come back and migraine was so ba get my pain medica vomit. My head pair complained to the s getting my pain med has really improved today because my pable to do therapy to	PM R2 was lying in bed with a mit that was sitting on her d at this time, "The nurse has checked on my pain. My d that I am vomiting now. If I tion quickly then I do not in is still excruciating. I have upervisors before about dications timely and nothing. I cannot even do therapy wain was so bad. I need to be o get my skilled stay covered be. The facility did nothing for all my pain."				
	stated, "The nurse of after getting my pair terrible. The next no something around 9	AM, R2 was lying in bed. R2 lid not check on me yesterday pill. My migraine was urse that came on gave me :00 PM. I needed something be keep the migraine away."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (DENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED			
!		IL6016794	B. WING	<u></u>	08/2	29/2019
	PROVIDER OR SUPPLIER	3089 OLD	DRESS, CITY, S JACKSONV			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	documents R2 is com MDS documents R2 effects sleeping at a R2's current Physic document R2 has the Carcinoma, Muscle (Non-Retractable), same POS's document R2 has the Carcinoma, Muscle (Non-Retractable), same POS's document Buprofen 200 mg (Infour hours as needed one tablet every six Tylenol-Codeine #3 six hours for migrainevery shift. Skilled six times a week and (PT) seven days a very shift. Skilled six times a very shift.	a Set (MDS) dated 8-8-19 orgitively intact. This same 2 has frequent pain that hight. ian's Order Sheets (POS's) he diagnoses of Bile Duct Weakness, Migraine and Chronic Pain. These ment the following orders: milligrams) two tablets every defor pain. Phenergan 25 mg hours for nausea. 300-30 mg one tablet every he headaches. Assess pain Occupational Therapy (OT) and Skilled Physical Therapy week." ent dated 8-2-19 documents y of pain at a "eight" with a evere pain that is his same assessment tions: Analgesics, Cold, ues, and Rest. Ian of Care documents, and for pain due to weakness, whepatic bile duct cancer, minia. Goal: Pain medication guest indicating effectiveness of being medicated. Approach: born admit and per protocol. ordered. Reposition as comfort."	S9999			
	documents, "Attemption (R2) states that she	ment Note dated 8-26-19 Ited to see (R2) twice today. is having a migraine and has puked this morning.				,

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ C B. WING IL6016794 08/29/2019

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

3080 OLD TACKSONWILLE BOAD

BRIDGE CARE SUITES 3089 OLD JACKSONVILLE ROAD SPRINGFIELD, IL 62704					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S9999	Continued From page 7	S9999			
	Pain is an 'eight' on 0-10 scale. Nursing aware. Patient refused to participate in skilled therapy."				
	R2's OT Daily Treatment Note dated 8-26-19 documents, "Guest was approached multiple times today, however complained of nausea/migraine. The patient declined to sit on the edge of the bed due to reports that she might get sick. The patient is limited due to nausea/migraine."				
	R2's Grievance Form dated 8-19-19 documents, "(R2) states that she does not have her pain medication, specifically Tylenol #3, when needed. According to nursing, they (nursing) have had some issues with receiving the prescription for (R2's) Tylenol#3, and therefor (R2) has missed a dose.			93	
	R2's Controlled Drug Record dated 8-16-19 documents the pharmacy sent four Acetaminophen/Codeine 300-30 mg tablets on 8-16-19. This same record documents the last dose of Acetaminophen/Codeine 300-30 mg was administered on 8-19-19 at 12:25 AM. R2's Controlled Drug Record documents R2 did not receive more Acetaminophen/Codeine 300-30 mg tablets until 8-21-19.				
	R2's Medical Record and Pharmacy Records do not include and documentation of a refill request being sent to pharmacy for R2's Acetaminophen/Codeine 300-30 mg on 8-19-19 or 8-20-19.				
	R2's Pain Assessment dated 8-19-19 at 7:00 PM to 8-20-19 at 7:00 PM documents R2's pain level at a "six" indicating R2 was experiencing "distressing, miserable pain" while out of the Acetaminophen/Codeine 300-30 mg.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		SURVEY PLETED
		IL6016794	B. WING			C 29/2019
NAME OF	PROVIDER OR SUPPLIER		DESS CITY S	STATE, ZIP CODE		23/2013
	CARE SUITES	3089 OLD		ILLE ROAD		
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S9999	Continued From pa	ge 8	S9999			
	light was on. At 9:2 light. R3 informed of pill for a migraine are turn R3's call light of and then reported to	10 AM to 9:28 AM R3's call 8 AM V10 answered R3's call V10 that she needed a pain and nausea. V10 proceeded to ff, answered R2's call light, b V5 (Licensed Practical was requesting a pain pill in the pain pain pain pain pill in the pain pain pain pain pain pain pain pain				
	on for 40 minutes b told the CNA I need headache and stom 'seven' on a 0-10 so pain pills here." At	O AM, R3 stated, "My light was efore a CNA answered it. I ed a pain pill. I have a bad lach ache. My headache is a cale. It takes forever to get this time R3 was holding her ead and had tears in her eyes.				
	with R3's scheduled that time noticed V5 R3 stated, "My migr pain pill. I am naus by stating, "You hav Hydrocodone since nothing else ordere and get the Hydrocodone	last night and you have d for pain. I will have to try odone ordered in a little bit." ed a Zofran 8 mg for R3's				
	again. V10 answer that she needed the pain. V10 proceede that R3 was in pain.					
	On 8-26-19 at 1:30	PM, R3 stated, "I still have not				

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STATEMENT OF DEFICIENCIES (X1) PR

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IL6016794	B. WING	-		C 29/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
BRIDGE	CARE SUITES	3089 OLD	JACKSONVI ELD, IL 6270	ILLE ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 9	S9999			
S9999	gotten a pain pill. I headache. My pain and excruciating. I On 8-26-19 at 2:12 that R3 was still need on 8-27-19 at 9:00 edge of the bed eat did not get my pain yesterday. My head migraine. The migraup vomiting that niggo without my pain nothing for me to try R3's MDS dated 8-2 cognitively intact. R3's current POS didiagnoses of Sciatic Ostoearthritis, Malig Chronic Pain, Neop Nausea/Vomiting. The following orders Hydrocodone-Aceta every four hours as Lidocaine 2.5 perceareas as needed for shift. R3's current Pain Pl'Problem: Potential	am nauseous from my is a 'nine' on a 0-10 scale need a pain pill now!" PM, V6 (CNA) reported to V5 eding a pain pill. AM, R3 was sitting on the ing breakfast. R3 stated, "I pill until after midnight d was pounding with a sine was debilitating. I ended th. I should have never had to medication. The staff did to help my migraine." 7-19 documents R3 is ocuments R3 has the ca, Low Back Pain, gnant Lung Cancer, Migraine, lasm related pain, and These same POS's document	S9999			
	Pain medication will indicating effectiven being medicated. A upon admit and per	ain, and migraines. Goal: be effective as guest ess within 30 minutes of approach: Pain assessment protocol. Pain medications tion as needed/desired for				

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6016794 08/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3089 OLD JACKSONVILLE ROAD **BRIDGE CARE SUITES** SPRINGFIELD, IL 62704 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 10 S9999 comfort. R3's Pain Assessment Section Pain Symptoms dated 8-15-19 is incomplete and does not address how often R3 has pain. This same assessment documents R3's pain is usually severe pain that is horrible/intense. constant/persistent, and analgesics used for the pain are usually effective. This assessment also documents that no other non-pharmacological interventions are used to manage R3's pain. R3's Controlled Drug Record documents 29 tablets of Acetaminophen 7.5/325 mg were delivered to the facility on 8-16-19. This same Controlled Drug Record and R3's MAR documents R3's last dose of Hydrocodone-Acetaminophen 7.5/325 mg was administered on 8-25-19 at 1:10 PM. R3's Medical Record dated 8-16-19 to 8-25-19 has no evidence documented of R3's physician being notified of the need for a refill request prescription for the Hydrocodone/Acetaminophen 7.5/325 mg before administering the last dose on 8-25-19 at 1:10 PM. The facility's Pharmacy Records do not include evidence of a Controlled Substance refill request form being sent to the facility or to R3's Physician. R3's Progress Notes dated 8-26-19 at 10:26 AM and 1:27 PM and signed by V5, documents V5 left a message with V15's office requesting R3's Hydrocodone/Acetaminophen 7.5/325 mg. R3's Progress Notes dated 8-26-19 at 2:28 PM and signed by V5, document V5 left a message for V18 (R3's Oncologist) requesting Hydrocodone. R3's Progress Notes dated 8-25-19 to 8-26-19 do not include any documentation of V2 or V14 (Medical Director) being notified of the need to

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6016794 08/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3089 OLD JACKSONVILLE ROAD **BRIDGE CARE SUITES** SPRINGFIELD, IL 62704 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) \$9999 Continued From page 11 S9999 get a short script to fill R3's Hydrocodone/Acetaminophen 7.5-325 mg. On 8-28-19 at 3:05 PM V15 (R3's Physician) stated, "The facility should have got ahold of a physician to reorder (R3's) Hydrocodone before (R3) ran out on Monday (8-26-19)," V15 confirmed that R3 should not have had to with stand excruciating pain from morning until night time on 8-26-19, or go without pain control. On 8-28-19 at 1:40 PM, V2 (Director Of Nursing) stated, "I was not notified of R2 running out of her Tylenol #3 on 8-19-19 or R3 not having her Hydrocodone on 8-26-19. I should have been told so I could have notified the Medical Director (V14) to try and get the medication prescriptions." On 8-29-19 at 9:10 AM, V19 (Pharmacist) stated, "A refill request was sent on 8-23-19 for (R3's) Hydrocodone-Acetaminophen 7.5-325 mg, but the facility never had the physician fill out the controlled substance refill form that is required before the pharmacy can send the medication out. The facility ordered (R3's) Tylenol #3 on 8-15-19 and the pharmacy sent four tablets on 8-15-19. The facility did not request any more refills for (R3's) Tylenol #3 until 8-20-19." R3's MAR dated 8-1-19 to 8-26-19 documents R3 did not get a Hydrocodone-Acetaminophen 7.5/325 mg until 11:59 PM on 8-26-19. On 8-26-19 at 9:15 AM, R4 was lying in bed and stated that she had a headache. R4 stated. "I

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'seven' on a 0-10 scale."

asked for Tylenol for a headache and haven't got it yet. My call light was on for 30 minutes before the CNA finally answered it. My headache is a

PRINTED: 11/04/2019 FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6016794 08/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3089 OLD JACKSONVILLE ROAD **BRIDGE CARE SUITES** SPRINGFIELD, IL 62704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG DEFICIENCY) S9999 Continued From page 12 S9999 On 8-26-19 at 9:53 AM V5 administered two Tylenol tablets 325 mg orally to R4. On 8-26-19 at 11:00 am, R4 requested a Norco from V5. R4 stated, "The Tylenol is not helping and my headache is getting worse." V5 replied to R4 that R4 needed to wait at least one half hour. I need to do (administer medications) to two other residents first. V5 told R4 that she needs to "Hang in there." R4's MDS dated 8-7-19 documents R4 is cognitively intact. R4's current POS document R4 has the diagnoses of Pain in the right hip, Nausea, and Diabetic Neuropathy. This same POS documents the following orders: Acetaminophen (Tylenol) 325 mg two tablets every six hours as needed for pain. Hydrocodone-Acetaminophen 10-325 mg one to two tablets every four to six hours as needed for pain (not to exceed eight tablets daily). Assess pain every shift. R4's current Pain Plan of Care documents. "Problem: Potential for pain and weakness due to right hip pain, left patella fracture, and restless leg syndrome. Goal: Pain medication will be effective by guest indicating effectiveness within 30 minutes of being medicated. Approach: Ice as ordered. Pain assessment upon admit and per protocol. Pain medication as ordered. Reposition as needed."

R4's MAR dated 8-26-19 and signed by V5 documents, "Acetaminophen 325 mg two tablets given at 10:16 AM. This same MAR documents

the Tylenol as effective for pain control."

Illinois Department of Public Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6016794	B. WING		1	C
NAME OF I	PROVIDER OR SUPPLIER				1 08/2	29/2019
			JACKSONV	STATE, ZIP CODE		
BRIDGE	CARE SUITES		ELD, IL 627			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 13	S9999			
	receive Hydrocodor 12:50 PM, even tho	26-19 documents R4 did not ne 10-325 mg two tablets until ugh R4 requested the 00 AM.				
	On 8-27-19 at 10:20 AM, R10 was lying in bed. R10 stated, "I have had open heart surgery, Ostoearthritis, and osteoporosis. I have severe pain, unless I get a pain pill (Tramadol) every six hours. I will put on my call light to ask for pain medicine 20 minutes early, because I know it will take at least that long to get my light answered. I usually have to wait at least another hour to two hours after the call light is answered to get my pain medicine. I start to get excruciating pain the goes from my back down my legs. Today I waited on my call light to get answered for over an hour this morning because I wanted a Tramadol." R10's current POS documents R10 has the diagnoses of Muscle Weakness, Pain, Cervical Disc Disorder, Disc Degeneration, Dorsalgia (Back Pain). This same POS documents the following orders: Oxycodone 5 mg one tablet					
		ophen 37.5-325 mg every two urs as needed for pain.				
	"Problem: Potential Cervical Disc Disord Degeneration. Goa effective as guest in 30 minutes of being assessment upon a	Plan of Care documents, for Pain due to Dorsalgia, der, and Lumbar Disc l: Pain medication will be dicates effectiveness within medicated. Approach: Pain dmit and per protocol. Pain ed. Reposition as needed."				
	R10's Pain Assessm documents R10 has	nent dated 8-23-19 moderate pain daily that is				

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	SLIBVEA
	OF CORRECTION	IDENTIFICATION NUMBER:	' '			LETED
					-	
		IL6016794	B. WING		08/2	; 9/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
BBIBOE	0.45E 0.117E0			/ILLE ROAD		
BKIDGE	CARE SUITES	SPRINGFI	ELD, IL 627	704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 14	S9999			
	constant. This same assessment documents analgesics are used to manage pain. On 8-26-19 at 1:38 PM, V5 stated, "(V10) reported to me that (R2, R3, and R4) needed pain medications between 9:00 and 9:28 am. I got the wrong room number for one resident. I would not expect a resident to lay in pain for any length of time. I usually don't have that many residents needing pain medications. I should have assessed all three resident's pain before giving other residents all of their medications. (R3) does not have anything else prescribed for pain. I did go back and tell (R4) to wait on her pain medication. I should not have made (R4) wait for Norco. I should not have documented that (R4's) Tylenol was effective for the pain. That was an error on my part."					
	confirmed that R3 s stand excruciating p	PM V15 (R3's Physician) hould not have had to with pain from morning until night go without pain control.				
	stated, "A nurse sho as soon as possible medication. The nut three residents (R2, assessment, find our resident rate the pai medication she had medication pass. The evaluated (R2) and medication pass with					

A. BUILDING:	
IL6016794 B. WING	C
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP O	2010
BRIDGE CARE SUITES 3089 OLD JACKSONVILLE ROA SPRINGFIELD, IL 62704	7.7
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EAC	OVIDER'S PLAN OF CORRECTION (X5) H CORRECTIVE ACTION SHOULD BE COMPLETE PREFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
S9999 Continued From page 15 On 8-26-19 at 11:45 AM, R1 stated, "It took a long time to get pain medication there (the facility). I would suffer with Heartburn and Diarrhea sometimes for hours. The heartburn would cause me severe chest pain. I had diarrhea the whole time I was at the facility and would not get a pill for the diarrhea. The diarrhea caused me to have stomach pain continuously. I made my daughter take me home because I was not getting good care at the facility." The Physician Order Sheet dated 7/26/19 through 8/26/19 documents R1 has diagnoses of history of Malignant Neoplasm to the breast and lungs, Muscle Weakness, Sepsis with Nausear/Vomiting, and GERD (Gastro-Esophageal Reflux Disease without Esophagitis). R1's Minimum Data Set dated 8/9/19 documents R1 is cognitively intact. R1's Nurses Note dated 8/3/19 at 2:15 am documents "(R1) has reportedly had some diarrhea stool and complained of heartburn on previous shift. Will notify MD (Medical Doctor) office in the am (morning) or oncoming shift." R1's Nurses Note dated 8/4/19 at 4:00 am documents "(R1) Wants order for heartburn and diarrhea." R1's Nurses Note dated 8/3/19 at 5:36 am documents "(R1) wants order for heartburn and diarrhea." R1's Medical Record dated 8/3/19 through 8/7/19 does not document that a physician was notified of R1's request for heartburn medication until 8/8/19. R1's Medical Record dated 8/3/19 through 8/13/19 does not document that a	DEFICIENCY)

AND PLAN OF CORRECTION I IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IL6016794	B. WING			C 29/2019
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY,	STATE, ZIP CODE		
BRIDGE	CARE SUITES		JACKSON\ ELD, IL 627	VILLE ROAD 704		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT: (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	Continued From pa	ge 16	S9999			
	physician was notifi medication until 8/1	ed of R1's request for diarrhea 4/19.				
	documents "Call ma office." and "(R1) w	ated 8/8/19 at 3:54 PM ade to (V16 Physician's) ould like to have PRN (as artburn Medication) order.				:
	documents "(R1) ha wanted doctor calle AM shift nurse mad	dated 8/13/19 at 5:06 am ad diarrhea this shift and d for anti-diarrhea medication. e aware that (R1) had one 8/12 (19) HS (bedtime)."				
	dated 8/14/19 at 9:5 placed to (V16) to g	actical Nurse) Progress Note i7 AM documents "Called et an order for Zofran (anti im (anti diarrhea) for (R1)"				
	Practical Nurse) and	signed by V5 (Licensed d dated 8/14/19 at 3:26 PM rec'd (received) N.O. (new d Zantac PRN."				
	through 8/26/19 doc (heartburn) was not The 7/26/19 through	er Sheet (POS) dated 7/26/19 cuments an order for Tums obtained for R1 until 8/9/19. a 8/26/19 POS does not r R1 to have Imodium or			P.	¥1
	7/27/19 through 8/20 received Imodium o	ministration Record dated 0/19 documents R1 never r a medication for diarrhea dent at the facility (7/27/19				
		ed V5 remembered taking the the Zantac for R1 and stated				

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING IL6016794 08/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3089 OLD JACKSONVILLE ROAD **BRIDGE CARE SUITES** SPRINGFIELD, IL 62704 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 17 S9999 V5 must have taken the order for Imodium at the same time. V5 reviewed R1's physician order sheet dated 7/26/19 through 8/26/19 and confirmed the orders for R1's Zantac and Imodium were not entered into the computer system. On 8/28/19 at 1:40 PM, V2 Director of Nurses could not provide documentation that V16 was notified of R1's request for heartburn medication before 8/8/19 or that V16 was notified of R1's request for anti diarrhea medication before 8/14/19. V2 stated V2 would expect staff to have notified R1's Physician (V16) of R1's requests for medication within 24 hours. V2 confirmed that when the orders for Imodium and Zantac were received they were not entered into the Electronic Medical Record so the medications did not appear on the Electronic Medication Administration Record so the nurses could administer the medications to R1. On 8-29-19 at 9:10 AM, V19 (Pharmacist) stated. "(R1's) Zantac and Imodium was never ordered from the pharmacy. (A)